



Department of Veterans Affairs

CLAIM FOR MONTHLY PAYMENTS
UNITED STATES GOVERNMENT LIFE INSURANCE (USGLI)

1. INSURANCE FILE NUMBER

F -

2. INSURANCE POLICY NUMBER

K

3. NET AMOUNT PAYABLE

4. BENEFICIARY'S SHARE (FRACTION)

5. PAYMENT OPTION
SELECTED
BY INSURED**IMPORTANT - Use this form for K prefix policies ONLY. PLEASE TYPE OR PRINT IN INK WHEN COMPLETING THIS FORM****BENEFICIARY** - This form is to be used only when monthly payments were selected by the insured, or the beneficiary is selecting monthly payments instead of one sum. See the directions on the reverse side if you wish to select a Lump Sum Payment.**SIGNATURE** - In order to expedite payment of this claim Item 16 must be signed by the beneficiary. If the beneficiary is a minor or incompetent, the person having custody of the beneficiary should complete the form and give his/her address in Item 12.

6. FIRST, MIDDLE AND LAST NAME OF INSURED VETERAN

7. DATE OF BIRTH

8. INSURED'S PLACE OF DEATH

9. FIRST, MIDDLE AND LAST NAME OF BENEFICIARY

10. RELATIONSHIP TO INSURED

11. BENEFICIARY'S DATE OF BIRTH

12. ADDRESS OF BENEFICIARY OR THEIR GUARDIAN

13. BENEFICIARY'S DAYTIME
TELEPHONE NUMBER14. BENEFICIARY'S SOCIAL SECURITY
NUMBER

()

15. Read the instructions on the reverse side and consult the tables attached before making your selection in the space below. Check (✓) the box for the option selected, or more than one box if more than one option is selected in accordance with instruction 2 on the reverse side. If selecting Option 2, please complete all items on the line checked.

OPTION NUMBER

OPTION DESCRIPTION

☐

2

MONTHLY INSTALLMENTS PAYABLE FOR 36 TO
240 MONTHS (In multiples of 12)NUMBER OF EQUAL MONTHLY
INSTALLMENTS (In multiples of 12)☐

3

MONTHLY INSTALLMENTS CONTINUING THROUGHOUT THE LIFETIME OF THE BENEFICIARY
WITH 240 PAYMENTS GUARANTEED. **PROOF OF AGE REQUIRED.**☐

4

MONTHLY INSTALLMENTS CONTINUING THROUGHOUT THE LIFETIME OF THE BENEFICIARY
WITH 120 PAYMENTS GUARANTEED. **PROOF OF AGE REQUIRED.**☐

5

THIS OPTION IS AVAILABLE TO THE BENEFICIARY ONLY WHEN THE INSURED DIES WHILE
RECEIVING TOTAL PERMANENT DISABILITY PAYMENTS. THE BENEFICIARY MAY ELECT TO
RECEIVE THE REMAINING MONTHLY INSTALLMENTS.

NOTE - Settlement under one of these options shall be considered full and complete settlement of all liability under this contract. This selection shall not be valid unless and until it is recorded in the Department of Veterans Affairs. If the beneficiary fails to select an option, settlement will be based on the option selected by the insured.

IMPORTANT - This form must be signed by the beneficiary, guardian or fiduciary, in Item 16, in order for payment to be made. If the beneficiary cannot sign his/her name, but is competent to handle his/her own affairs, an "x," made by the beneficiary and signed by two disinterested witnesses, is acceptable.

16. SIGNATURE OF BENEFICIARY, FIDUCIARY OR GUARDIAN

17. DATE

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, PLEASE CALL OUR TOLL-FREE NUMBER 1 (800) 669-8477